1977-03-11

P/S/R/O update: March 11, 1977 no. 30

P/S/R/O Update

Boston University Medical Center

March 11/77
Number 30

The Medical Cost/Quality Newsletter

Mid-Atlantic group, irked at lack of response on PSRO concerns, forms 'action' team

Concerned over what they see as a continued lack of response by the federal government to their concerns, a group of PSRO representatives from Regions II and III, known as the Mid-Atlantic Conference, have decided to form an "action committee" to take their case to the new administration, the National PSR Council and the American Association of PSROs.

RESPONSE 'INSULTS' HIM

Reacting to a letter that said, "We will repond to your concerns," Harry C. Kuykendall, M.D., of Northern Virginia Foundation for Medical Care, said, "This kind of a response to this organization insults me." He was referring to a letter from the director of the Bureau of Quality Assurance, Michael J. Goran, M.D., who had replied to earlier communications from the Mid-Atlantic Conference in which these issues had been raised: level-of-care determinations, long-term-care review, direct conditional designation of PSROs, physician reimbursement and PSRO review of private-pay patients.

Kuykendall told the group, which met Feb. 9 in Cherry Hill, N.J., "This is a

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INSIDE STORIES

House unit sets hearings for April 4, 6, to weigh status of PSRO program

The oversight subcommittee of the House Ways and Means Committee has set April 4 and 6 for hearings on PSROs.

The topic for the first day will be the status of implementation, with testimony scheduled to come from the Institute of Medicine, the General Accounting Office and the Bureau of Quality Assurance. Subcommittee staff aide Carl Smith said, "We plan to look at what's necessary to make the program work, how costs are justified, what types of review seem to be better than other types and, in general, how to make the program more successful.

"The second day," he continued, "we'll look at the efficiency, coordination and effectiveness of the program. For example, program-review teams are set up in some areas to do the same [things] the PSRO does, [suggesting that] the whole system is probably not as efficient as it could be."

The preliminary line-up of witnesses for April 6 includes the Blue Cross Association, Bureau of Health Insurance, American Hospital Association, Joint Commission on Accreditation of Hospitals, American Association of PSROs, Health Resources Administration, and American Medical Records Association, Smith reported.

Last year the oversight subcommittee held hearings on PSROs under its former chairman, Rep. Charles A. Vanik (D-Ohio), who has moved to another committee. The

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PSRO Update, which covers the federally mandated Professional Standards Review Organization program and the broader field of medical cost and quality, is published monthly by Boston University Medical Center Address editorial inquiries to **PSRO Update,** 720 Harrison Avenue, Suite 300, Boston, MA 02118. Telephone (617) 247-5606. Address subscription inquiries to **PSRO Update,** 306 Dartmouth Street, Boston, MA 02116, Telephone (617) 267-7100. Executive Editor/Donald R. Giller. Managing Editor/Owen J. McNamara. News Editor/Barbara Mackey. Contributing Editors/Nancy Haslam, Lorraine Loviglio, John Blum. Correspondents throughout the nation. Staff assistants/Carol Bernbaum, Rose Razzino.

House unit sets hearings for April 4, 6, to weigh status of PSRO program

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new chairman is Rep. Samuel Gibbons (D-Fla.).

Rep. Philip Crane (R-Ill.), is prominent as a subcommittee member for the position he has taken on PSROs: He opposes them. This year he has reintroduced a bill to repeal the PSRO law, and has filed several bills to guard the privacy of medical records. Crane's aide for health, Linda Durfee, explained, "Representative Crane voted against the PSRO bill originally in 1972, and has introduced a repeal amendment every year since then. He feels that PSRO just puts politicians into medicine. The program has the effect of putting the doctor on the defensive. For example, if a doctor intends to keep a patient in the hospital for six days, when the PSRO has said the maximum is five days, the doctor has to defend his action."

Smith expects Crane "to ask a lot of important questions at the hearing, especially on areas of confidentiality and cost benefits." ■

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complete lack of response. What we're falling heir to is what our colleagues warned us about--'you'll get caught up in the bureaucracy,' they said. We thought we'd not let it happen, that we'd be energetic, bright, enthusiastic. "Well, gentlemen, we're not heading them off at all!" he said.

Other participants echoed Kuykendall's expression of outrage, and they suggested a variety of steps. Ultimately, the group chose an "action committee" composed of Kuykendall; George Ross Fisher, M.D. (Philadelphia PSRO); Ann Allen-Ryan (Kings County [N.Y.] PSRO); Irving Burka, M.D. (National Capital Medical Foundation); Mort Kurtz, M.D. (Queens County [N.Y.] PSRO); and Daniel J. O'Regan, M.D. (New Jersey Support Center). The group was expected to meet this month to map out a strategy. Guest speaker at the conference, June Jackson Christmas, M.D., who is the New York City Commissioner of Mental Health, agreed to assist the committee as an adviser.

Christmas had recently finished a two-month stint as head of the DHEW transition team for then President-elect Jimmy Carter.

A COST EMPHASIS

She described her job in Washington as one of identifying problems for the new administration, not developing policy options.

Christmas advised the conference that the administration's first thought is with costs. "From the first meeting," she said, "the message from Carter was, 'You must be concerned with costs.' I was a bit troubled by the emphasis," she noted.

Christmas said she was "impressed with [Carter's] grasp of health matters." And closer to the matter of medical peer review, she said, "He was concerned with whether we physicians especially, could police ourselves."

Other topics covered at the meeting were relationships between hospitals and the Joint Commission on Accreditation of Hospitals; computer analysis of summary data; reactions to a draft transmittal on reimbursement; relationships between a PSRO and a health-systems agency, and progress of two new groups, for executive directors and review coordinators, within the AAPSRO.

The next meeting will be convened by the National Capital Medical Foundation. The date is not yet set. ■

Hospital-cost 'lid' plan sets keynote for Carter approach to DHEW budget

WASHINGTON, D.C.--The centerpiece of Jimmy Carter's first domestic budget is a proposed lid on hospital costs, estimated by the administration to be rising at a 15-percent-a-year rate. It is proposed as a necessary prelude both to national health insurance and to permanent controls of some kind on hospital charges for services to patients.

REACTIONS PRO AND CON

The plan came under expected fire from such quarters as the American Hospital Association and the Federation of American Hospitals, but won endorsements from the Blue Cross plans and the National Governors' Conference.

"We must restrain the voracious appetite of health-care cost before it consumes whatever dividends there are from social economic policy," DHEW Secretary Joseph A. Califano Jr. said in describing the President's proposal. Then, after a luncheon with members of the Governors' Conference

human resources committee, Califano told newsmen that rising hospital costs threaten in several years to divert $3 billion annually from the government services for children and older persons.

The plan, if approved by Congress, would limit the increase in the amount of money a hospital receives for the care it provides. Ceilings would be negotiated, probably through state hospital associations, for allowable increases in hospital reimbursements from all sources. "This means that no hospital could increase its overall level of charges--to Medicare or Medicaid, to third-party insurers or to individual patients who pay for services out of their own pockets--by more than the negotiated and federally sanctioned ceiling," according to DHEW, which would administer the controls through a new unit staffed by 125 persons.

The controls would begin Oct. 1, the beginning of fiscal year 1978.

Califano eschews any description of the proposal as wage-price controls, preferring to call it "hospital-costs containment."

'HYPOTHETICAL' 9 P.C.

The proposed legislation would direct the DHEW Secretary, working with a national advisory committee, to set the limits on cost increases. The administration has been talking in a hypothetical sense of a 9-percent limit on hospital costs in fiscal 1978. However, the 9-percent example is increasingly being mentioned by Califano as something more certain than an illustration. Still, the law would not set any ceiling. It would instead provide the mechanism for negotiating a ceiling, or ceilings, depending on whether it is a national ceiling or one allowing for regional variations. A 9-percent ceiling in the year beginning Oct. 1 would save taxpayers $829 million on Medicare and Medicaid spending and would cut nonfederal spending by $1.6 billion, Califano told a House appropriations subcommittee March 1.

Exceptions would be allowed for labor or certain capital expenses already programmed, but the administration is urging hospital administrators to hold the line on further increases while the plan is prepared. "It would be tragic if the effort to control the escalation of hospital costs were undercut by any attempt on the part of hospitals to raise charges, without economic justification, before the program goes into effect," said Califano. If that happens, the legislation may have to include some sort of retroactive mechanism "to nullify the benefits of such improper conduct," he said.

Other budget items:

--President Carter approved the Ford administration's $72.2-million request for PSROs. This represents an increase over fiscal year 1977 of $11,109,000 and 40 new positions. It would allow for expansion of the PSRO program and conversion of 83 planning PSROs to conditional status.

--Carter is seeking a $35-million increase to find alternatives to abortion. The money would be spent on expanded family planning, including contraceptive services; pre- and post-natal health care for mothers and infants; adoption and foster care; sex education and counseling; and basic research in reproductive biology.

--Carter would freeze the Part B Medicare premium at $7.20 a month for 25.4 million elderly and disabled Americans. The premium was scheduled to increase to $7.70 in July. ■

April 8 deadline set as last national call for physician PSRO proposals

Although nearly ten months remain before nonphysician groups may become eligible for funding as PSROs, the government has announced a deadline of April 8 for its last national solicitation of proposals from physician groups.

A 1975 amendment to the PSRO law provided that groups other than physicians may be considered for planning contracts after the first of next year.

It has not been determined, said Dennis Siebert, director of the division of program operations of the Bureau of Quality Assurance, whether this "last national solicitation of proposals" will offer the last opportunity to physician groups to submit proposals.

"We don't know if we can solicit proposals selectively after this cycle. It's something we have to talk about with the contracts office," Siebert said.

If it turns out that no additional proposals will be accepted after the April 8 deadline, it may put pressure on physicians in some "uncovered" areas to act sooner in order to head off the possibility of a group of nonphysicians coming in next year with a PSRO organization plan.

In Georgia, for example, physician leaders "have said all along that they will come in, but that they will wait until the

eleventh hour to do so," Siebert said. Georgia is one of only three states, Nebraska and Texas being the others, in which there is no PSRO activity yet.

25 AREAS 'UNCOVERED'

By the end of this month, BQA expects to have funded 50 planning and 105 conditional PSROs. That leaves about 25 PSRO areas "uncovered," counting Texas as a single area, Siebert said.

The question of single or multiple areas in Texas has not been settled yet, he said. The next step is up to Secretary of DHEW Joseph Califano, who is expected to review former Secretary David Mathews's decision to declare a single area. If Califano concurs with his predecessor, he would be expected to approve a final regulation to follow the proposed regulation published Dec. 28, 1976, redesignating Texas as a single area.■

Transmittal on MCEs attempts to minimize BQA, JCAH differences

To guide PSROs in doing medical-care evaluation studies, the Bureau of Quality Assurance has issued a final transmittal (#43) which it characterizes as "a first step toward minimizing the potential for disagreement between PSRO and the Joint Commission for Accreditation of Hospitals."

The transmittal, dated Jan. 25, "is an attempt to propose uniform definitions and to adopt common number requirements to satisfy both PSRO and JCAH requirements," BQA notes.

However, the transmittal states that MCE studies "may be conducted, utilizing a wide variety of procedures and methodologies....Each study (should be) designed to specific objectives...for improving the quality of care."

REQUIREMENTS STATED

According to BQA, designers of each MCE study should:

--focus on a known or suspected problem;

--define the topic well;

--use written criteria that compare with actual patterns of practice;

--draw the data sample from all patients in a hospital, not just Medicare and Medicaid patients;

--provide for peer analysis when discrepancies appear between written criteria and actual patterns of care;

--where problems are uncovered, write recommendations to individuals, boards or committees responsible for quality assurance;

--document the implementation of recommended actions;

--plan a follow-up evaluation, where indicated, and then do the evaluation within one year of the MCE study; and

--report to the hospital governing board summaries of quality-assurance activities and specific results of any studies that require board action.

The transmittal outlines requirements a PSRO must follow in implementing an MCE program.

AGREEMENT REACHED

BQA and JCAH have agreed on several points: using the same number of audits; employing a calendar year as the "reporting year;" and considering the JCAH term "patient-care evaluation" and the BQA term "medical-care-evaluation study" to mean the same thing.

The number of required audits ranges from four MCE studies for a hospital with less than 2,500 annual admissions to 12 medical audits for a hospital with 20,000 or more admissions.

Under the 1976 JCAH policy, MCEs conducted by hospitals for PSRO-sponsored areawide studies will be accepted as patient care audits provided that the hospital meets the following requirements:

--review and approval of the study design and criteria by the hospital medical staff, either directly or by staff representation on the responsible PSRO committee;

--collection of data from the hospital's own patient records;

--analysis of results by the hospital's medical staff;

--enforcement of corrective measures, where needed, by the appropriate hospital authority;

--follow-up study and report of corrective actions taken by those responsible for quality of care.

This JCAH policy for acceptance of PSRO areawide audits applies only to hospitals that are delegated. The Joint Commission has not developed a policy on non-delegated hospitals.■

Plan worked out to give PSRO Liaison Network formal DHEW status

The group of nonphysician health professionals that had been "accredited" as an informal liaison by the National PSR Council last September lost its status early this year when a DHEW legal opinion

declared that the group had to be formally appointed by the DHEW Secretary.

The National Council had appeared unwilling to give the "Liaison Network" official advisory status last September when the issue arose. However, in January, the Council voted unanimously to recommend that official advisory status be sought by the Bureau of Quality Assurance.

The process of formal appointment has begun, according to Geraldine Ellis, of BQA; the National Council will be asked at its next meeting, March 21-22, to approve and send to the Secretary a plan worked out by BQA that would sanction the group as advisory to that body.

COMMENTS OFFERED

In its three or four months of existence, the "Liaison Network" had met twice and sent to the National Council comments on long-term care review, ancillary services and PSRO advisory groups, according to a report by spokesperson Patricia Ostrow at the January Council meeting.

The group had representatives from 20 national associations of professionals, such as pharmacists, podiatrists, dieticians, radiological technicians, medical records analysts, occupational and physical therapists, optometrists, psychologists, social workers, dentists and nurses.

Notably absent from the roster were representatives of American Dental Association, the American Society of Oral Surgeons and the American Nurses Association. These organizations have actively sought PSRO involvement through seats on the National and state councils and through actual membership in PSROs. To this end, they have had bills introduced in several sessions of Congress to amend the PSRO law, which now bars them. To date they have been unsuccessful.■

Carter budget documents offer examples of PSRO potential for cutting costs

WASHINGTON, D.C.--The Carter administration has told Congress it has new evidence of dollar savings from PSRO review.

In backup budget material sent to Congress with President Carter's fiscal year 1978 spending proposals, the administration said only limited data are available on peer review.

LOS SHORTER, QUALITY UP

"However, early indications from conditionally designated PSROs have found evidence that where PSRO review is implemented, hospital lengths of stay are shorter than under previous conditions, quality is improved, and unnecessary use of services is controlled," Congress was told.

The budget material cites these examples, including at least one unpublished study:

--Multnomah Foundation for Medical Care, Oregon: A 1974/1975 comparison of pre-PSRO and post-PSRO experience showed reductions in the average length of stay at 10.4 percent for Medicare patients and 23.5 percent for Medicaid patients, which translates to 48,852 fewer patient days of care after the initiation of PSRO review over a one-year period.

--South Carolina Medical Care Foundation: A study of two six-month periods (Oct. 1974-March 1975 for pre-PSRO and Oct. 1975-March 1976 for post-PSRO) conducted by the South Carolina Department of Social Services found that review resulted in .9 days reduction in average LOS for Medicaid patients. The reductions were statistically significant when compared both to pre-PSRO experience and to a control group of hospitals not yet under PSRO review.

--Delmarva Foundation for Medical Care, Maryland: 1976 data on LOS at the three largest hospitals were compared to LOS data in 1974 and 1975, which was prior to PSRO review. The results showed that average LOS was reduced by .5 days for both Medicare and Medicaid patients.

--Wyoming Health Service: A comparison of 1974 pre-PSRO LOS to 1975 post-PSRO LOS in Wyoming showed a reduction of .98 days in average Medicare hospitalization and .17 in average Medicaid LOS. The number of Medicare admissions also declined by 24 percent.

--Sacramento Foundation for Medical Care: An unpublished study of the Sacramento PSRO Certified Hospital Admission Program (CHAP) by the Social Security Administration showed overall reductions in hospital use as a result of peer review. The analysis revealed that after the first year of Medicare CHAP review, patient days per 1,000 enrollees fell by 5.3 percent in the CHAP area, while they rose by 4.6 percent in five comparison areas. CHAP review resulted in an estimated savings of 16,500 days of care in the first year with estimated dollar savings of almost $1 million compared to program costs of $279,000.

POSITIVE BENEFIT CITED

"It is believed that nationwide PSRO hospital reviews will continue to result in dollar savings from reduced utilization by curtailing the provision of unnecessary services and/or preventing payment for services provided at inappropriate levels of

care," the budget document said.

"Although extensive data are not available at this time to make a precise estimate of the amount of these savings, all relevant studies continue to demonstrate a positive cost benefit."

The so-called budget justification documents are sent to congressional appropriations panels.■

San Francisco conference examines ambulatory care

With many PSROs doing review of acute care, more attention now turns to ambulatory care quality-assurance programs.

Health Care Management Systems, Inc., a nonprofit corporation, and the Bureau of Quality Assurance will sponsor a conference March 31-April 1 in San Francisco to examine research results and describe programs and problems of implementing ambulatory-care review.

Conference speakers include: Michael Goran, M.D., director of BQA; Nicole White, Ph.D., director of research for HCMS; Leslie Ford, M.D., Division of Peer Review, BQA; Paul J. Sanazaro, M.D., University of California Medical School in San Francisco; Robert H. Brook, M.D., Sc.D., University of California, Los Angeles, and the Rand Corporation; Joseph Gonnella, M.D., Jefferson Medical College; Paul Batalden, M.D., St. Louis Park Medical Center in Minneapolis; and Leonard Rubin, M.D., Kaiser-Permanente Medical Care Program in Northern California.

Further information about the conference funded jointly by BQA and the Robert Wood Johnson Foundation, can be obtained by calling HCMS at (714) 454-3015, or writing 470 Nautilus St., Suite 207, La Jolla, CA 92037.■

BQA sets out its schedule for confidentiality rulemaking

DHEW's final regulation on confidentiality, to be issued sometime in April, will provide a firm, but partial, answer to the current question about which PSRO data are disclosable (to a health systems agency, for example).

The answer will be incomplete, according to the Bureau of Quality Assurance, because it will cover only the disclosure of PSRO data that have already been made public from other sources, and the disclosure of information aggregated from the Uniform Hospital Discharge Data Set. These areas were the subject of a notice of proposed rulemaking published Dec. 3, 1976.

The full confidentiality regulation has been planned for publication in proposed form in August 1977, according to Mark Tabak of BQA's office of program development.

TRANSMITTAL POLICY HOLDS

To guide PSROs until final regulations have been published, BQA has issued transmittal letters (#16 and #41) enunciating its policy. These transmittals ban the release of nonprivileged PSRO data to anyone except authorized government agencies and the institutions or individuals that supplied the information in the first place. (See PSRO Update, Nov. 1976.)

In view of the complexity of the subject of confidentiality and the change in DHEW administration, meeting the August target for the full proposed rule is now questionable, Tabak said. The calendar also shows January, 1978, as the projected month for final full regulations on confidentiality, but this, too, would be in doubt if the proposed regulations are not published when now planned.

Following is a schedule prepared by BQA of the expected publication of regulations:

FINAL REGULATIONS:

--confidentiality (interim final): April 1977
--state PSR councils: June 1977
--advisory groups to state councils: June 1977
--hospital review procedures: July 1977
--assumption of review responsibility:

NOTICE OF PROPOSED RULEMAKING:

--reconsideration and appeals: May 1977
--alternative organizations: July 1977
--financing review costs: July 1977
--sanctions: August 1977
--confidentiality: August 1977
--waiver of liability: September 1977■

PSR council members named for Connecticut, California

Members of PSRO councils in Connecticut and California were named in late January, completing the list of the first group of six state PSR councils. PSRO Update, in December and January issues, published the names of members of the Massachusetts, New York, Pennsylvania and Maryland councils.

CONNECTICUT

Members for the PSR council of Connecticut are: Andrew P. Owens, M.D., PSRO of Fairfield County; David A. Grendon, M.D., Connecticut Area II PSRO; Andrew J. Canzonnetti, M.D., Hartford County PSRO; and

Robert S. Gillcash, M.D., Eastern Connecticut PSRO.

Also, Isadore H. Friedberg, M.D., and Jerome K. Freedman, M.D., both chosen by the Connecticut State Medical Society; and Lawrence K. Pickett, M.D., and Leopold M. Trifari, M.D., chosen by the Connecticut Hospital Association.

Connecticut's public members are: Estelle Siker, M.D., director of community health, Connecticut Department of Health; Cornell Scott, M.P.H., executive director of Hill Health Center, New Haven; Elinor Marie Healy, M.S.W., director of social work at Norwalk Hospital; and David Reick, a nursing-home administrator at Triage, Inc. in Plainville, Connecticut.

CALIFORNIA

The California council members and their affiliations are: Habeeb Bacchus, M.D., Ph.D., Riverside County PSRO; William A. Beck, Jr., M.D., Area XXIV PSRO; Edwin W. Butler, M.D., California Area XXII PSRO; John J. Cawley, M.D., Kern County PSRO; James O. Farley, M.D., Greater Sacramento PSRO; Harry R. Glatstein, M.D., Santa Clara Valley PSRO; Harvey I. Goodman, M.D., San Joaquin Area PSRO; John M. Kenney, M.D., Redwood Coast Region PSRO; Kenneth M. Kressenberg, M.D., North Bay PSRO; Earl B. Rubell, M.D., California Area XX PSRO; Nancy G. Thomson, M.D., San Francisco Peer Review Organization; and Joseph E. Turner, M.D., Monterey Bay Area PSRO.

Other members are Sanford Feldman, M.D., and Woodbury Perkins, M.D., chosen by the California Medical Association; and Linda Hawes Clever, M.D., and Homer C. Pheasant, M.D., chosen by the California Hospital Association.

California public members are: Rahemah Amun, a community mental-health education consultant in San Francisco; Lee Helsel, a rehabilitation health professional and deputy director of the Medi-Cal Division, California Department of Health; Elizabeth M. Schilling, a trustee of the California Hospital Association and member of the former San Francisco Comprehensive Health Planning Council; and Phyllis R. Smith, chairperson of the California Health Facilities Commission, a state advisory group.■

AAPSRO's Fullerton is given DHEW cost-control role

Secretary of DHEW Joseph Califano has drawn from the PSRO arena in choosing a special consultant on health-cost containment. William Fullerton, director of the American Association of PSROs and the American Association of Foundations of Medical Care, left to accept the DHEW advisory position beginning Feb. 28.

Before joining the AAPSRO/AAFMC last year, Fullerton had served on the staff of the Subcommittee on Health of the House Ways and Means Committee.■

PSRO, HSA should address data issue with due regard to PSRO-hospital relationship

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impact that this may have on PSRO-hospital relations. One of the purposes in providing assurances of confidentiality of medical data collected by the PSRO is to encourage health-care practitioners and institutions to be candid and forthright in providing data. Without such protection from disclosure, the provision of such data may be influenced by considerations of self-protection and fear of abuse and distortion. Under such conditions, the PSRO-hospital relationship, painstakingly cultivated to yield mutual trust, may instead become divisive and adversary with the PSRO being perceived as an extension of an unempathetic, amorphous governmental bureaucracy. It would hardly be surprising if such an adversary relationship diminished the integrity and accuracy of the data emanating from the hospital.

A POSSIBLE SOLUTION

Although the means for dealing with this dilemma will never be simple, a solution may be found in the development of a comprehensive set of procedures for disclosure that requires the PSRO to:

--give a hospital prior notification that the PSRO intends to disclose hospital-specific data;

--disclose only data that have been analyzed and interpreted by the PSRO; or

--provide the hospital with the opportunity to include comments or explanations in any report from the PSRO to the HSA.

Such procedures will, to some extent, protect the hospital from the surprise of learning of such a report's disclosure via the local newspaper. The procedures will help diminish the possibility of distortion of "raw" data and will go a long way in assuring the institution and the PSRO of the fairness and accuracy of the data presented.■

Eleanore Rothenberg, Ph.D.
David Schimel

COMMENTARY

PSRO, HSA should address data issue with due regard to PSRO-hospital relationship

The following article by Eleanore Rothenberg, Ph.D., executive director, and David Schimel, data director, of the New York County Health Services Review Organization, examines some problems in the relationship between a PSRO and an HSA. In discussing the need for reaching agreement on data, the authors give particular attention to the needs of hospitals and to the importance of the PSRO's maintaining a good relationship with the hospital, even with the prospect of having to transmit identifiable institutional data to the HSA.

In the relationship between a Professional Standards Review Organization and a health systems agency, the current need is to develop a memorandum of understanding that satisfies the key issue, the exchange of data. The three other areas to be covered in an MOU ("review and comment" by the PSRO, exchange of technical assistance, and keeping PSRO actions consistent with HSA plans) are less complex. The issue of data handling, however, is made especially difficult because the two agencies are expected to resolve, on the local level, certain conflicts that exist in federal policies. The resolution through an MOU could have considerable impact on a PSRO's relations with its hospitals.

BUILT-IN CONFLICT

PSROs and HSAs are both authorized by federal laws; both need data to perform their mandates; and both have certain statutory provisions as well as regulations governing the handling and disclosure of data.

By law and by regulation, PSROs are to generate, collect, process and analyze their own data, which are to be used solely for PSRO purposes. PSRO-generated data are confidential and may not be disclosed for non-PSRO purposes unless authorized by regulation.

HSAs, on the other hand, must make their records and data available to the public for inspection and copying. Moreover, HSAs must acquire data collected by other agencies from those agencies and are discouraged from collecting and processing their own data.

This built-in conflict in the approach to data access and acquisition is understandable because PSROs are physician-membership organizations that operate on the premise that data must be held in confidence. In contrast, HSAs have broad, representative constituencies, with a consumer majority on boards and committees, and operate on the premise that data should be freely shared and openly displayed.

ELEMENTS OF MOU

HSA regulations published on March 26, 1976 call for an MOU between HSAs and PSROs (encompassed in whole or in part in the HSA area) to be entered into within six months after an HSA is conditionally designated. At a minimum, the MOU must cover four types of activity, of which the most important is the sharing of data and information, such as statistics on patterns of utilization and quality of care, subject to the PSRO confidentiality policy restrictions.

The only PSRO regulations on confidentiality issued thus far are the proposed interim regulations published Dec. 3, 1976. Section 101.1702 of these regulations requires that the PSRO disclose, upon request, summary statistics aggregated from the Uniform Hospital Discharge Data Set, subject to the condition that such data must not explicitly or implicitly identify a patient or a physician.

The HSA regulations instruct the HSA to obtain certain PSRO statistical data reflecting patterns of quality of care, but such data certainly transcend what can be derived from the UHDDS alone. To gauge quality of care, one needs information such as profiles (individual or institutional) and/or medical care evaluation study findings. The issue to be resolved is how and where the line is to be drawn between confidential data and disclosable data.

A NOTABLE OMISSION

Since the PSRO regulations are silent on the question of identifying institutions, this noteworthy omission tends to support the PSRO "grapevine" predictions that the federal policy eventually will classify as nonprivileged PSRO data on individual institutions.

Assuming that the PSRO must disclose such hospital data, one must consider the

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